Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOLLY VINSANT MEMORIAL HOSPITAL
302 KINGS HIGHWAY SUITE 112
BROWNSVILLE TX 78521

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number: 54

MFDR Tracking Number

M4-05-A198-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our position is that the billing in dispute has not been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies, rules, and the Texas Labor Code. The TWCC has not assigned Maximum Allowable Rates for the services the subject of this claim. TWCC Rule 134.401(a)(4) specifically states that Ambulatory/Outpatient surgical care, is not covered by the Acute Care Inpatient Hospital Fee Guidelines. It further states that such fees shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement. In MDR: M4-04-1813-01, The Division ruled that evidence of redacted copies of payments made by other carriers for similar treatment I the same geographical area was a proper method to determine the fair and reasonable rates. Furthermore, Dolly Vinsant asserts that no contractual relationship exist between it and Rockport Healthcare Group. The Agreement between Dolly Vinsant and carrier's representative, (Newtown Healthcare Network, LLC), because invalid in 1998. As Newton Healthcare Network LLC was acquired by Rockport Healthcare Group in 1998, New Healthcare Network was required to obtain written consents from Dolly Vinsant to transfer and assign agreement to Rockport. Since this did not occur, Dolly Vinsant has not contract with Rockport in connection with this claim."

Amount in Dispute: $13,538.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual's total reimbursement to DOLLY VINSANT HOSPITAL was $490.64, below the adjusted HOPPS rate. Texas Mutual will issue a supplemental payment of $657.16 ($1147.80-$490.64). When the physician fee schedule MAR for code 76003 is added to the 148% of codes 72295 and 72100, the total amount is $1,147.00. In contract DOLLY VINSANT HOSPITAL billed $13,905.00 for the technical portion of this procedure. In the absence of any credible information from DOLLY VINSANT HOSPITAL justifying its payment rate, Texas Mutual believes its supplemental payment has ensured the hospital has received a payment that is fair and reasonable."

Response Submitted by: Texas Mutual Insurance Co., 221 W. 6th Street, Ste. 300, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 1004	Outpatient Surgery	$13,538.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 7, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 15, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F – Fee guideline MAR reduction.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - M – No MAR.
   - 713 – Fair and reasonable reimbursement for the entire bill is made on the 'O/R Service' line item.
   - 793 – Reduction due to PPO contract.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 143 – Portion of payment deferred.
   - 420 – Supplemental payment.
   - 891 – The insurance company is reducing or denying payment after reconsidering a bill.

Findings

1. According to the explanation of benefits, the services in dispute were paid using a contracted fee arrangement. Tex. Lab. Code Ann. §413.011(d-3) states that the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On November 3, 2010 the division requested a copy of the contract between the network and the health care provider. The carrier failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed in accordance with the Texas Labor Code and Division rules.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of

all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).

5. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
7. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
8. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "the Division ruled that evidence of redacted copies of payments made by other carriers for similar treatment in the same geographical area was a proper method to determine the fair and reasonable rates."
   - The requestor did not submit documentation to support that redacted copies of payments by other carriers for similar treatment in the same geographical area was a proper method in determining fair and reasonable rates.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.